This was followed by a considerable pain and stiffness which was thought to be rheumatic. Some months afterward, following severe emotional disturbance the left hand and later the entire extremity began to shake. When the case was reported the most important symptoms, without entering into details, were as follows: The objective symptoms were, muscular rigidity, tremor, mask or expressionless face, characteristic attitude of Parkinson's disease. Subjectively, there were, sensations of twitching, desire to continually change position, great and easily induced fatigue. The symptoms that are frequently found in paralysis agitans and which were absent in this case, were the sensation of heat, which in this patient was replaced by a sensation of cold, and propulsion and retropulsion.

In addition to this group of symptoms, he presents exaggeration of the knee and masseteric reflex and epileptoid trepidation. The stigmata of hysteria, which are well defined, are, concentric limitation of the visual field, dyscromatopsia, loss of sense of smell and of taste. The author remarks that the change in the reflexes are suggestive respectively of change in the lateral pyramidal columns and the ganglionic elements of the cerebro-spinal axis, but the supposition of such a lesion can be quickly excluded in this case, and that the exaggeration of the reflexes are dependent on the hyper-excitability of the spinal centres which is so frequently seen in hysteria. He further remarks that the co-existence of these two diseases does not interfere with the conception that we have of them, from a pathological standpoint. As the author suggests that the two diseases, paralysis agitans and hysteria have a very close relationship, it is probable that he does not accept very seriously the view of degenerative or leust nutritional changes that have been described by many recent writers on paralysis agitans as existing in the gray matter of the brain and spinal cord. J. C.

Two Cases of Epilepsy Dependent Upon Alterations in the Nose.—Dr. F. Kjellman, of Stockholm, describes two cases of epilepsy in children due to alterations in the nasal cavity. The first case, a school boy of 12 years, had for four years suffered from epileptiform attacks, which usually appeared in the morning. He would be found with his head buried in the pillow, his face distorted, his body completely rigid and unable to speak and unconscious. This would persist for fifteen to twenty minutes and be followed by headache and languor. The attacks increased in frequency and were associated with involuntary urination, appearing at other times, as on going to bed or even during the day. Later, the seizure was accompanied with tonic spasms in the left side of the face, in the tongue and neck muscles. No tendency to nervous diseases in the family. The mucous membrane of the lower turbinated bones was found soft and hypertrophic. These were cauterized and he was free from the seizures for eight months when another was observed. Renewed cauterization and freedom from attacks. The writer has found about fifteen cases, in the literature where epileptic attacks were found; to cease after treatment of morbid changes in the nasal cavities. The conditions mentioned are polypi, foreign bodies and hypertrophies of the mucous membrane of the turbinated bones, especially that of the lower. This first case he explains as of reflex origin. The second case was a boy of 6 years, who, for the last two and a half years, had been observed to have spasmodic seizures during the morning while still in bed. When but slight, as it sometimes was, the spasm appeared only in the left hand and arm, with consciousness. In the more severe ones, respiration was groaning, his face pale, and his mouth open. On his mother taking him into her arms he would cry out: "I am suffocating." The spasms involved the entire body, he was entirely unconscious, the skin was cold and clammy, and on awakening he could not move his left arm, in which he complained of formication and a numb feeling. Usually after this he would fall into a deep sleep and on waking could scarcely stand upon his feet. His attacks were worse whenever he had a cold. A moderately well developed, soft and diffuse swelling of the mucous membrane of the right lower turbinated bone was discovered. This was cauterized, and as he was in the habit of sticking his fingers into his nose during sleep, his arms were encased in stockings. Three seizures, two of slight violence, followed this, and since then he has been free from them. In this case he regards the disease as due to impeded respiration from the child's habit of sleeping with his fingers in his nose, and not from the hypertrophy. From these he concludes that not all cases of nasal origin are dependent upon irritation of the nasal filaments of the trigeminus, and that in certain cases of so-called nocturnal epilepsy the seizure may be preceded by an asthmatic attack and be due to impeded respiration.—*Hygiea*, No. 2, 1893. F. H. P.

On Simulation of Concentric Contraction of the Visual Field in the Traumatic Neuroses.—In an article in the *Deutsch. Med. Wochenschrift*, 1892, No. 24, Schmidt-Rimpler does not absolutely ignore the contraction of the visual field as a symptom of the traumatic neuroses, but finds adequate justification for such a view in one case under his observation. When a marked contraction of the field is claimed in the absence of objective findings, he considers a certain amount of suspicion as to simulation as warranted. Oppenheim's view that such simulation in typical form cannot be carried out, or else only by an exceptionally clever and regularly trained impostor, he declares to be incorrect. In some way the customary permietric examination gives suggestions for eventual simulation, inasmuch as the patient at first really believes, and then tries to make the examiner believe, that he first sees the object brought from the periphery only when he distinctly perceives it. The acuteness of vision makes it possible for the simulator to always keep within the same limits of excentric vision.

As a test of credibility, the writer recommends the compimetric method of examination, published by him in 1885. He uses the so-called scotoma-board by means of which he measures the field, first at one-half m., then at double and triple distance. The field must increase correspondingly with the distance of the board. The simulator generally refers the peripheral appearance of the object at the same distance from the centre. Another test depends upon the fact, that by means of a prism, the picture of the peripheral object (which is supposed to be seen for the first time), is thrown upon a still further peripheral portion of the retina, which is not sensitive. If both eyes are left open, the similator asserts that he sees double images, one of which shows a colored border owing to the action of the prism.

The negative result of this attempt at simulation does not prove absolutely the reliability of the patient, as he may be so far instructed that he knows all the conditions that are to be considered in this case. The positive result bespeaks, undoubtedly, unskilful intentional deception, and cannot be explained by any special psychical process, such as amaurosis and contracted field in hysteria. There is no reason why the results of the cam-